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10/92 B. Excluded and Exempted Hospitals and Hospital Units: General Rules

1. Criteria

10/92 A hospital will be excluded from the DRG PPS if it meets the criteria for one or more of the classifications described in Section C. of this Chapter.

09/91 2. Alternate Reimbursement System

All excluded hospitals (and excluded distinct part hospital units, as described in Section D. of this Chapter) are reimbursed under the Alternate Reimbursement Systems set forth in Chapter VIII, with the exception of county-owned hospitals in a county of over 3 million in population which are reimbursed under the methodology set forth in Chapter XIII., and state-owned hospitals in a county of over 3 million in population which are reimbursed under the methodology set forth in Chapter XIV.

09/91 C. Excluded Hospitals: Classifications

Hospitals that meet the requirements for the classifications set forth in this Section may not be reimbursed under the DRG Prospective Payment System.

1. Psychiatric Hospitals

A psychiatric hospital must:

a. Be primarily engaged in providing, by or under the supervision of a psychiatrist, psychiatric services for the diagnosis and treatment of mentally ill persons; and

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10/92 b. Be enrolled with the Department as a psychiatric hospital to provide inpatient psychiatric services (category of service 21) and have a Provider Agreement to participate in the Medicaid Program.

2. Rehabilitation Hospitals

A rehabilitation hospital must:

a. Hold a valid license as a physical rehabilitation hospital; and

10/92 b. Be enrolled with the Department as a rehabilitation hospital to provide inpatient rehabilitation services (category of service 22) and have a Provider Agreement to participate in the Medicaid Program.

3. Children's Hospitals

A children's hospital must:

== 10/93 a. Be a hospital devoted exclusively to caring for children. A hospital which includes a facility devoted exclusively to caring for children that is separately licensed as a hospital by a municipality shall be considered a children's hospital to the degree that the hospital's Medicaid care is provided to children; and

b. Have a Provider Agreement to participate in the Medicaid Program.

10/92 4. Long Term Stay Hospitals

10/92 A long term stay hospital must:

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a. Not be a psychiatric hospital, as described in Section C.1. above, a rehabilitation hospital as described in Section C.2. above, or a children's hospital as described in Section C.3. above, and must have an average length of inpatient stay greater than 25 days: as computed by dividing the number of total inpatient days (less leave or pass days) by the number of total discharges for the most recent State fiscal year for which complete information is available; and

b. Have a Provider Agreement to participate in the Medicaid Program.

5. Hospitals Outside of Illinois that are Exempt from Cost Reporting Requirements

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A hospital is excluded from the DRG PPS if it meets the following definition: a nonparticipating out-of-state hospital is an out-of-state hospital that provides fewer than 100 Illinois Medicaid days annually, that does not elect to be reimbursed under the DRG PPS, and that does not file an Illinois Medicaid cost report.

6. Hospitals Reimbursed Under Special Arrangements

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Hospitals that, on August 31, 1991, had a contract with the Department under the ICARE Program, pursuant to Section 3-4 of the Illinois Health Finance Reform Act, may elect to continue to be reimbursed at rates stated in such contracts for general and specialty care for services provided on or after September 1, 1991, subject to the limitations described in Sections H. through J. of Chapter VIII.

7. Sole Community Hospitals

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Hospitals described in Chapter VI.B.1., which have elected to be exempted from the DRG PPS, subject to the limitations described in Sections H. through J. of Chapter VIII.

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== 10/93 8. County-Owned Hospitals and Hospitals Organized Under the University of Illinois Hospital Act

== 10/93 County-owned hospitals located in an Illinois county with a population greater than three million and hospitals organized under the University of Illinois Hospital Act are excluded from the DRG PPS and are reimbursed under unique hospital-specific reimbursement methodologies as described in Chapters XIII. and XIV.

09/91 D. Excluded Distinct Part Hospital Units

1. Distinct Part Psychiatric Units

With the exception of those hospitals described in Sections C.1. through C.8. of this Chapter, a hospital enrolled with the Department to provide inpatient psychiatric services (category of service 21) shall be excluded from the DRG PPS for the reimbursement of such inpatient psychiatric services and shall be reimbursed in accordance with Chapter VIII.

2. Distinct Part Rehabilitation Units

With the exception of those hospitals described in Sections C.1. through C.8. of this Chapter, a hospital enrolled with the Department to provide inpatient rehabilitation services (category of service 22) shall be excluded from the DRG PPS for the reimbursement of such inpatient rehabilitation services and shall be reimbursed in accordance with Chapter VIII.

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III. Conditions for Payment Under the DRG Prospective Payment System

09/91 A. General Requirements

1. A hospital must meet the conditions of this Chapter to receive payment under the DRG PPS for inpatient hospital services furnished to persons receiving coverage under the Medicaid Program.

2. If a hospital fails to comply fully with these conditions with respect to inpatient hospital services furnished to one or more Medicaid clients, the Department may, as appropriate:

   a. Withhold Medicaid payment (in full or in part) to the hospital until the hospital provides adequate assurances of compliance; or

   b. Terminate the hospital's Provider Agreement.

09/91 B. Hospital Utilization Control

10/92 Hospitals and distinct part units that participate in Medicare (Title XVIII) must use the same utilization review standards and procedures and review committee for Medicaid as they use for Medicare. Hospitals and distinct part units that do not participate in Medicare (Title XVIII) must meet the utilization review plan requirements in 42 CFR, Ch. IV, Part 456, Subparts C, D, or E (October 1, 1991). Utilization control requirements for inpatient psychiatric hospital care in a psychiatric hospital, as defined in Chapter II.C.1., shall be in accordance with Federal regulations at 42 CFR, CH. IV, Part 456, Subpart G (October 1, 1991).

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09/91 C. Medical Review Requirements: Admissions and Quality Review

Hospital utilization review committees, a subgroup of the utilization review committee, a designee of the utilization review committee, or the hospital's designated professional review organization (PRO) shall review, on an ongoing basis, the following:

1. The medical necessity, reasonableness and appropriateness of inpatient hospital admissions and discharges.

2. The medical necessity, reasonableness and appropriateness of inpatient hospital care for which additional payment is sought under the outlier provisions of Chapter V.

3. The validity of the hospital's diagnostic and procedural information.

4. The completeness, adequacy and quality of the services furnished in the hospital.

5. Other medical or other practices with respect to program participants or billing for services furnished to program participants.

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09/91 D. Medical Review Requirements: DRG Validation

1. Physician attestation. Beginning with admissions on or after September 1, 1991, for which the discharge occurs on or after December 15, 1991, the attending physician must, shortly before, at, or shortly after discharge (but before a claim is submitted), attest to the principal diagnosis, secondary diagnoses, and names of major procedures performed. The information must be in writing in the medical record and, except as provided in Section D.2. of this Chapter, the physician must sign the statement. Below the diagnostic and procedural information, and on the same page, the following statement must immediately precede the physician's dated signature:

   "I certify that the narrative descriptions of the principal and secondary diagnoses and the major procedures performed are accurate and complete to the best of my knowledge."

   The physician's name must be typed or clearly printed and appear on the same page as the physician's signature.

2. Alternative signature requirement. The attending physician's signature, along with the other information required in Section D.1. of this Chapter, may be provided by electronic means through a hospital data system if the hospital's Title XVIII (Medicare) intermediary has determined that the hospital data system meets the guidelines established by the Health Care Financing Administration, U.S. Department of Health and Human Services, under the Medicare Program.

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3. DRG Validation. The Department or its designee may require and perform prepayment review and/or postpayment review of specific diagnosis and procedure codes.

4. Sample Reviews

   a. The Department, or its designee, may review a random sample of discharges to verify that the diagnostic and procedural coding, submitted by the hospital and used by the Department for DRG assignment, is substantiated by the corresponding medical records.

   b. Code validation must be done on the basis of a review of medical records and, at the Department's discretion, may take place at the hospital or away from the hospital site.

5. Revision of Coding

   a. If the diagnostic and procedural information, attested to by the attending physician, is found to be inconsistent with the hospital's coding, the hospital shall be required to provide the appropriate coding and the Department shall recalculate the payment on the basis of the revised coding.

   b. If the information attested to by the physician as stipulated under Section D.5.a. of this Chapter is found not to be consistent with the medical record, the hospital shall be required to provide the appropriate coding and the Department shall recalculate the payment on the basis of the revised coding.

09/91 E. Medical Review Requirements: The Department, or its designee, may conduct pre-admission, concurrent, pre-payment, and/or post-payment reviews of:

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1. The medical necessity, reasonableness and appropriateness of inpatient hospital admissions and discharges.

2. The quality and/or nature of the utilization of health services.

3. The medical necessity, reasonableness and appropriateness of inpatient hospital care for which additional payment is sought under the outlier provisions of Chapter V.

4. The validity of the hospital's diagnostic and procedural information.

5. The completeness, adequacy and quality of the services furnished in the hospital.

6. Other medical or other practices with respect to program participants or billing for services furnished to program participants.

Hospitals shall be notified at least thirty (30) days in advance of any pre-admission, concurrent, or pre-payment review requirements imposed by the Department.

09/91 F. Denial of Payment as a Result of Admissions, Length of Stay, Transfers and Quality Review

1. If the Department determines that a hospital has misrepresented admissions, length of stay, discharges, or billing information, or has taken an action that results in the unnecessary admission or inappropriate discharge of a program participant, unnecessary multiple admissions of a program participant, unnecessary transfer of a program participant, or other inappropriate medical or other practices with respect to program participants or billing for services furnished to program participants, the Department may, as appropriate:

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a. Deny payment (in whole or in part) with respect to inpatient hospital services provided with respect to such an unnecessary admission, inappropriate length of stay or discharge, subsequent readmission or transfer of an individual.

b. Require the hospital to take action necessary to prevent or correct the inappropriate practice.

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c. Perform prepayment review in accordance with Chapter VIII.L.3.

2. When payment with respect to the discharge of an individual patient is denied by the Department, or its designee, under Section F.1.a. of this Chapter, a reconsideration will be provided within 30 days, upon the request of a practitioner or provider, if such request is the result of the designee's own medical necessity or appropriateness of care denial determination and is received within 60 days of the Advisory Notice. The date of the Advisory Notice is counted as day one.

3. A determination under Section F.1. of this Chapter, if it is related to a pattern of inappropriate admissions, length of stay and billing practices that has the effect of circumventing the prospective payment system, may result in actions specified in Section A.2. of this Chapter.

== 10/93 G. Furnishing of Inpatient Hospital Services Directly or Under Other Arrangements

1. The applicable payments made under the PPS are payment in full for all inpatient hospital services other than for the services of nonhospital-based physicians to individual program participants and the services of certain hospital-based physicians as described in Sections G.1.b.i. through G.1.b.v. of this Chapter.